pected to salvage slightly better than one out of two patients with ruptured abdominal aneurysm who reach the operating room alive. Reduction in this continuing high mortality will be principally influenced by either earlier diagnosis and operation once rupture has occurred or by elective resection of the aneurysm before rupture. Operative mortality for an unruptured aneurysm averages 4 to 6 percent in skilled hands. It is of interest that the onset of symptoms in most patients heralds impending rupture and thus requires emergency surgical management. Operation at this time, before shock ensues, carries the low mortality associated with an elective procedure in an asymptomatic patient. Emergency operation in the symptomatic pre-rupture state is necessary because frank rupture can on occasion proceed with rapidity.

Every physician should be cognizant of the symptoms and signs of leakage in an abdominal aortic aneurysm. The cardinal symptom is sudden severe low back pain which is often accompanied by radiation to the back, flanks, pelvis, and groin. Signs of cerebral ischemia are also common at this time, depending upon the amount of blood lost into the retroperitoneal space. The confirming clinical sign is a palpable pulsating abdominal mass. While aneurysms 3 cm in diameter have been associated with rupture, the vast majority of those that rupture are 7 cm or more in diameter and are readily palpable.

Palpable aneurysm in a symptomatic patient warrants expeditious exploration. Such a patient may occasionally have both an unruptured aneurysm and other acute intra-abdominal disease, the latter causing the symptoms. A diagnostic error in such a patient will not cause his death; on the other hand, conservative management or even operation on a patient thought to have an inflammatory lesion but actually suffering from a ruptured aneurysm, may well delay the definitive treatment of a ruptured aneurysm if the surgeon is untrained in vascular procedures.

Elective excision and replacement of an aortic aneurysm can be safely performed in most patients regardless of the size of the aneurysm, the age and sex of the patient and the presence of associated disease. Patients with associated disease, moreover, can be expected to obtain a much longer life expectancy than that of patients not treated surgically. Surgical mortality is ten times less in patients with nonruptured than ruptured aneurysms. However, despite the continued high mortality of patients with ruptured aneurysms, they must continue to be treated surgically, for survival without operation is exceedingly rare.

When more physicians appreciate the safety of the operation in experienced hands as opposed to the natural history of the disease, we can expect a decrease in numbers of patients seen with ruptured aneurysms. Furthermore, an awareness of the symptoms and signs of early rupture of abdominal aneurysms should permit earlier operation and, hence, significant improvement in mortality figures for operations performed even after rupture has begun.

JOHN E. CONNOLLY, M.D.
Chairman, Department of Surgery, University of California, Irvine

The Specter of Malpractice

IN THIS ISSUE a new category of articles, *Student Contributions,* makes its start with a communication titled "The Specter of Malpractice," by Geoffrey E. Linburn.* We are publishing the article for two reasons. One is that we believe mature physicians and thoughtful students both can benefit from communications of this kind. More important, we believe that the author makes some points which the profession should hear.

To physicians with knowledge of the many programs that the California Medical Association is carrying on to assure good medical care and to protect patients from damage that may be done when they do not get it, cursory reading of the article will disclose some poorly founded assumptions and statements by the author. The items in question are to some extent attributable to reliance on dated sources, probably because more recent information is generally less publicized. They do, however, serve to call attention to the considerable progress that medical organizations have made in this field. For instance, Dr. Linburn relies on articles or statements which appeared in 1956-57. Those familiar with malpractice litigation and professional activities are aware that there have been great changes in the last dozen years. The author also seems unaware of vigorous efforts at many levels in the medical profession in California to improve practice and to enforce proper standards

*The author was a fifth year student at the Stanford University School of Medicine at the time he submitted the article; is now a Doctor of Medicine interning at Denver General Hospital.

of care. It is to be hoped that our young physicians will participate in the activities of society professional relations committees, peer review committees, hospital staff credentials, utilization, tissue and related committees, in CMA hospital survey committees, and in numerous similar efforts. Any physician accepting such responsibilities will quickly realize that California's physicians spend a great deal of time seeking to enforce the requisites of good medicine. As the author of "The Specter of Malpractice" notes, these efforts are laborious and may be thwarted by legal maneuvers. However, there is abundant evidence to dispel any belief in a "frequent, tacit agreement among physicians, not to hold one another accountable for a standard of care."

These errors should not distract from the very valid points which the author makes, among them that blaming the courts or the legal profession will not solve medicine's problems.

Affirmative efforts are necessary, based upon comprehension of public attitudes. The success of these efforts requires knowledgable participation by individual physicians, as well as their professional societies.

Power Tactics in Health Care

POWER PLAYS of one sort or another are becoming the order of the day in health care. For evidence that this is so one need only cite recent organized strikes by nurses, not only for wages, but for more administrative control of patient care as well; "heal-ins" conducted by associations of interns and residents for better working conditions and more pay; and, in another vein, certain clearly discriminatory uses of government power with respect to mandatory and arbitrary reductions of physician fees for services they have rendered. Practicing physicians have not been accustomed to such power tactics in health care and they are ill equipped to engage in this sort of conflict. Yet it is clear that health care is becoming an arena for social, economic and political conflict in our society and power plays of one sort or another are becoming an accepted part of the health care scene.

When one is set upon, whether it is by nurses, labor unions, government or even a physical assailant, there can be only three possible responses—surrender, counteraction, or no action (which is the non-violent position where one is only speaking of violence). Surrender is obviously totally self-defeating. Counteraction may also result in defeat, or perhaps in the defeat of the attacker; or, if neither of these occurs, some sort of balance of power may develop which may be more or less enduring. No action—that is, neither surrender nor counteraction—is ennobling to the soul and can sometimes be successful, provided one is willing to risk one's all for it; but in reality no action leaves most of the immediate options in the hands of those who would use power tactics to impose their will.

Like it or not, the medical profession and medical organizations are perforce participants in this arena of conflict in health care and they should not only hold their own but be among the strongest of the participants. To this end it would seem that when the inevitable conflicts come about, a policy of counteraction would usually be preferable to accepting the penalties of surrender or of no action. This of course implies that the medical profession will master the techniques of such power tactics as may be needed, become competent in their use, and be willing to use them in whatever conflict situation may arise. This will be a clear departure from traditional professional attitudes, but so is the growing acceptance and use of power tactics in health care. We had best get on with it as quickly as possible. The alternatives are becoming increasingly unacceptable in the interests of better medicine and better health care.